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Better Times and the Birth Rate

IN 1934—for the first time in 10 years—there was an increase in the American birth rate. It had dropped, in 10 years, approximately 26 percent, or, on the average, 2.6 percent per year*; between 1933 and 1934 it *rose* 3 percent.

The 1934 rise followed an increase, the year before, in the country's marriage rate, which, like the birth rate, had been persistently declining. We believe that the reversal of the trend for both marriages and births is the direct result of an upward turn in the economic tide. Better times have made it possible for thousands of young men and women to consummate marriages which the depression had forced them to postpone. And thousands of married couples have been enabled, through better times, to fulfill a fundamental obligation to society and themselves, namely, to bear and rear children.

The 1934 increase in the birth rate was nearly, although not quite general throughout the United States. Only one of the nine broad geographic divisions, the Middle Atlantic States, showed a reduction. Here the birth rate dropped $^{6}/_{10}$ percent last year owing to declines of 3.7 percent in New Jersey and 1.4 percent in New York; Pennsylvania registered a 1.9 percent rise. The increases in the rest of the United States ranged from a minimum of one percent in New England, to 6.1 percent in the East South Central Division, with all four States (Alabama, Kentucky, Mississippi and Tennessee) participating in the rise. Two of the six New England States (Massachusetts and Rhode Island) showed no change, and in Connecticut there was a small decline. The East North Central States (Ohio, Indiana, Illinois, Michigan, and Wisconsin) registered a rise of 2.7 percent, in which all five States shared; and all seven States of the West North Central group (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas) participated in the rise of 4.2 percent which was recorded for that section of the country.

*In the expanding United States Birth Registration Area.

Maryland was the only State to show a birth rate drop last year in the nine which constitute the South Atlantic Division. A rise of 4.8 percent was recorded for this area.

The West South Central region recorded a 5.2 percent increase in which three of the four states shared. Arkansas, however, recorded a drop of 3.7 percent. This is identical with the decline in New Jersey and is the largest in the country.

Every one of the Mountain States except New Mexico, and all three of the Pacific Coast States, had higher birth rates in 1934 than in the preceding year.

There were three States (Montana, North Dakota, and West Virginia) in which the rise in the birth rate amounted to more than 10 percent in a single year. Increases as large as these are so unusual that one is led to suspect the figures reported reflect, in part, improvement in registration in these particular States. It is impossible to determine to what extent this factor may be responsible for the increases reported. Nor is it possible to say definitely which of the States had the largest *actual* increase in the birth rate last year.

To summarize, there were increases in 40 states and the District of Columbia and decreases in six states. There was no change in the birth rate in two states, namely, Massachusetts and Rhode Island.

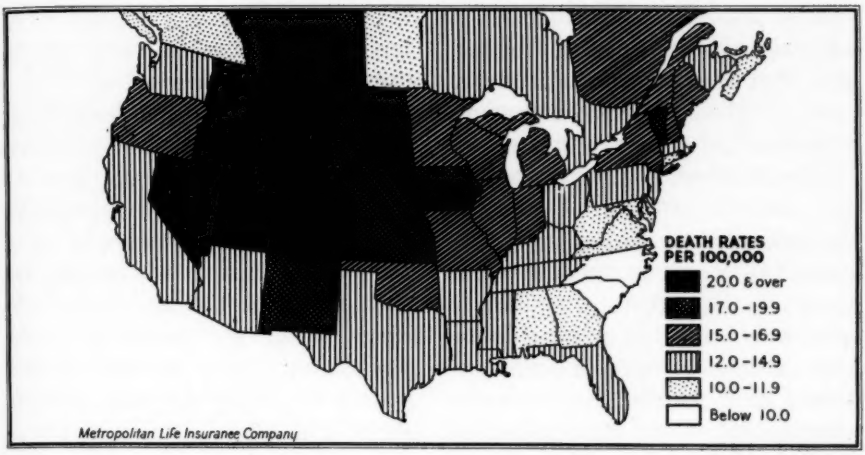
It is interesting to note that of the six States to show declines, three (New York, New Jersey, and Connecticut) form a continuous area with a highly industrialized population. In general, however, a higher birth rate was in evidence last year in both industrial and agricultural States.

Appendicitis and Hospital Facilities

APPENDICITIS as a cause of death is more frequently reported in the United States and Canada than in any other country of the civilized world. The death rate per 100,000 in these two countries during recent years has averaged around 14 to 15, whereas in Europe it has ranged from 3 in Spain to 12 in Switzerland. Furthermore, despite wider knowledge of the pathology of the disease, improved operative technique, and added hospital facilities, the mortality from appendicitis is today much higher among us than it was a quarter of a century ago.

Very likely this increase can be attributed partly to greater accuracy in diagnosis and to fuller registration of deaths, but these factors alone cannot account for the excessive appendicitis mortality in the greater part of North America. In many European countries diagnosis is just as accurate and registration even more complete than in America. One is therefore led to look for another explanation. It is hard to

GEOGRAPHIC DISTRIBUTION OF APPENDICITIS DEATHRATE
United States and Canada, 1929-1933



believe that Americans are inherently more prone to the disease than other peoples, or that their way of living is more apt to cause appendicitis. Certainly, also, American surgeons are at least equal in knowledge and operative skill to their European confreres.

Perhaps the accompanying map will throw some light on the problem. It will be observed that the very highest appendicitis death rates in the United States are to be found in the group of States composed of Montana, Idaho, Wyoming, Nevada, Utah, and Colorado. Especially high rates occur in the great agricultural States, the Dakotas, Iowa, Nebraska, Kansas, Missouri, Minnesota, etc. Various factors might be advanced in explanation of the high appendicitis death rates in these States, such as altitude, climate, age, race, and sex distribution of the population, etc. Careful checking of these factors, however, proves that they can have little or no influence on the high mortality reported by these States. Comparison of the appendicitis death rates of various localities according to altitude produced no evidence that this is a serious factor. Standardization of the death rates according to the age and sex distribution of the population does not change the picture, as the standardized rates are only slightly lower than the crude death rates.

The true explanation, probably, is to be found in the peculiar status of these States with respect to available hospital facilities. Nearly all of them, it will be noted, are sparsely inhabited; population centers containing hospitals are few and far between. Obviously, in these States persons stricken with appendicitis

must lose much time at the critical moment before they can obtain proper hospital treatment.

It is a fact, fully established by all qualified investigators of the subject, that the chances of a fatal outcome in this disease increase rapidly with the time elapsed between onset and hospitalization. In other words, the patient's chance of recovery depends almost entirely upon the speed with which he comes to operation. In these States, therefore, it is probable that the physical condition of patients arriving for operation is far less favorable to recovery than is that of the average patient in other States where distances are not so great.

It is interesting to note that in Canada, also, the highest appendicitis death rates are to be found in those provinces where similar conditions prevail—where population is sparse and hospitals are often hard to reach. In Alberta, for example, the appendicitis death rate ranges around 19 per 100,000, the highest reported in the Dominion. The next highest mortality is recorded in Saskatchewan (17 per 100,000) and the third highest in Quebec (16 per 100,000).

Apparent contradiction of this theory is to be found in the relatively high rates in States like Illinois, Michigan, Indiana, and New York. It is not a contradiction in fact, however, for in these States it is probable that the relatively high rates are due, not to the lack of, but rather to the presence of exceptional hospital facilities. These facilities undoubtedly attract many patients from near-by States, a certain percentage of whom die and tend to swell the mortality rates for the States with more ample hospital accommodation.

The low appendicitis death rates of certain South Atlantic States can be accounted for largely on the score of faulty diagnosis and incomplete registration. The presence of large numbers of negroes in the population of the South can have little effect since the mortality from appendicitis among the colored is only slightly less than that of the whites.

It can readily be seen, then, why appendicitis death rates in America exceed those of European countries. In Europe distances between population centers are comparatively small; hospitalization, consequently, can be obtained more speedily, thereby greatly improving the patient's chance of recovery. On the other hand, in large areas of America operation facilities are available, if at all, only after considerable difficulty and even hardship on the part of the afflicted person. It must be assumed, therefore, that in America a larger proportion of patients reach operation in a hopeless condition than is the case in most European countries.

For the reasons stated it does not seem likely that any great reduction of appendicitis mortality can be effected in certain areas of the United States until either hospital or transportation facilities are greatly improved.

The Comparability of Cancer Death Rates

ACCORDING to the crude death rates cancer is a more frequent cause of death among people who live in the Northeastern States than in other parts of the country. This is the conclusion to be derived from the mortality reports of the United States Bureau of the Census and of the various States. There is good reason for believing, however, that this situation is more apparent than real. In fact, we have here an excellent example of the misleading picture often presented by crude mortality rates.

Several circumstances lead to a higher cancer death rate in the Northeastern States. Of these we may mention first the superior hospital facilities of these States, and second, the higher average age of the population of this region, as compared with other sections of the United States.

Undoubtedly, the much better hospital facilities of the Northeast attract many cancer patients residing in other States. When these patients die in the hospitals, as many of them do, the deaths are charged against the State in which death occurs, instead of the State of residence. This method of recording naturally increases the crude cancer death rates of the Northeastern States and lessens those of States outside of this area.

Cancer is a disease concentrated heavily in later life; it is therefore to be expected more frequently in areas where many older people reside. The fact, then, that there is a larger proportion of elderly people in the populations of the Northeastern States than in the Southern and Western States accounts to some extent for the higher crude death rates from cancer in this section of the country.

But even making allowance for the differences in age distribution, we still find appreciably lower cancer mortality rates reported south of the Mason and Dixon line than in other parts of the United States, as is shown in Table I, by the standardized death rates of the several sections of the country. In the white populations of the Southern States the cancer death rates range from 50 per 100,000 in Arkansas, to 78 per 100,000 in Louisiana. In the general population of the Northeastern States the standardized cancer death rates range from 78 in Indiana to 107 in Rhode Island. In other words, the highest rate in the South is no higher than the lowest rate in the Northeast.

The true picture is revealed only upon careful analysis and comparison of the mortality reports in their entirety. We then find a clue to the situation in the fact that the Southern States report a much larger proportion of deaths of unknown or uncertain cause than do the Northeastern States. This indicates not only that diagnosis is less definite and accurate in the Southern States, but also that more people die without medical attention in this area

than elsewhere in the United States. Since about 40 percent of all deaths attributed to ill-defined and unknown causes, and of course, all deaths assigned to senility, occur among persons more than 45 years of age, the natural inference is that many of these should properly be charged to cancer.

In this connection Table I is enlightening. A brief study of it will show that where cancer mortality is high very few deaths are charged to "ill-defined" causes, and that low cancer death rates are regularly accompanied by high "ill-defined" death rates. The coefficient of correlation is remarkably high $-.819 \pm .049$.

During the period 1929–1931 the States with the highest cancer mortality showed death rates from senility and ill-defined causes not more than one tenth as high as the cancer death rate, but in most States where the cancer mortality was particularly low the "ill-defined" rate was nearly, if not quite, as high as the cancer death rate. In six States —Arizona, Mississippi, North Carolina, Tennessee, New Mexico, and

TABLE I

Standardized Death Rates per 100,000 Population from Cancer and Other Malignant Tumors and from Senility, Ill-Defined and Unknown Causes Combined in Each of the Registration States During the Period 1929–1931.

STATE	CANCER DEATH RATE	ILL-DEFINED AND SENILITY DEATH RATE	STATE	CANCER DEATH RATE	ILL-DEFINED AND SENILITY DEATH RATE
Rhode Island	106.9	10.7	Louisiana*	78.4	25.7
New York	104.7	3.4	Indiana	78.0	4.4
District of Columbia*	103.1	6.7	Utah	75.5	38.5
Massachusetts	100.5	2.9	Montana	74.7	21.0
Connecticut	96.2	7.5	Kansas	71.0	17.4
Minnesota	95.9	8.5	Idaho	70.6	25.2
New Jersey	95.7	5.7	North Dakota	69.2	31.1
Maryland*	93.1	6.5	South Dakota†	68.5	45.5
Illinois	93.0	9.0	Virginia*	67.7	38.9
California	90.9	5.0	Florida*	67.0	33.4
Maine	90.7	23.7	Arizona	65.7	99.4
Pennsylvania	90.3	8.4	Nevada	65.3	51.8
Wisconsin	89.6	10.4	Wyoming	65.1	31.4
New Hampshire	87.0	9.1	Kentucky*	64.5	27.9
Michigan	84.5	12.6	West Virginia	64.0	27.0
Washington	84.2	16.8	Alabama*	63.6	56.8
Ohio	83.6	10.2	Mississippi*	63.3	68.3
Nebraska	83.4	14.4	Georgia*	62.1	53.7
Missouri	81.8	14.5	North Carolina*	60.1	67.7
Iowa	81.4	15.7	Tennessee*	60.1	83.1
Oregon	81:3	9.0	Oklahoma*	57.5	49.1
Colorado	80.7	16.2	South Carolina*	56.0	39.2
Vermont	79.5	13.0	New Mexico	54.3	361.8
Delaware	79.1	9.3	Arkansas*	50.2	59.7

*White population only.
†For 1930 only.

TABLE II

Crude Death Rates per 100,000 Population from Cancer and Other Malignant Tumors and from Senility, Ill-Defined and Unknown Causes Combined, in Cities, Small Incorporated Places (2,500–10,000) and in the Rural Areas of Each State: 1930.

STATE	CANCER			SENILITY, ILL-DEFINED, UNKNOWN		
	Cities	Incorporated Places	Rural	Cities	Incorporated Places	Rural
TOTAL 41 STATES*	120.8	115.0	71.2	8.5	26.4	43.4
Rhode Island	138.2	88.5	136.6	9.1	11.8	20.9
New York	123.3	130.9	122.4	2.1	5.9	8.5
Massachusetts	133.6	109.3	175.8	3.1	2.7	3.3
Connecticut	124.0	140.0	107.5	7.0	16.0	9.8
Minnesota	166.4	148.5	81.2	5.3	15.3	12.8
New Jersey	105.7	94.1	109.8	3.9	5.0	6.6
Maryland†	137.5	166.1	85.0	3.9	10.8	11.8
Illinois	118.8	114.9	94.1	9.7	15.7	15.7
California	150.3	115.7	68.3	4.5	7.1	8.4
Maine	169.0	‡	133.8	24.1	‡	42.8
Pennsylvania	111.6	94.4	83.1	6.0	8.9	12.7
Wisconsin	131.3	142.9	93.8	6.8	15.5	16.7
New Hampshire	139.5	122.1	153.2	9.5	9.4	27.0
Michigan	87.1	109.9	96.5	7.1	19.2	26.1
Washington	141.3	193.5	67.7	9.2	52.7	26.5
Ohio	110.2	117.8	97.1	7.9	14.5	17.9
Nebraska	162.0	164.6	72.9	7.9	32.1	18.4
Missouri	137.0	136.3	78.4	4.2	19.6	26.6
Iowa	147.6	193.4	87.0	18.8	49.8	21.4
Oregon	165.9	171.2	58.8	6.2	27.4	11.8
Colorado	144.9	149.7	53.2	20.3	35.8	14.9
Vermont	132.7	‡	123.7	18.7	‡	23.5
Delaware	120.1	132.5	87.2	5.6	18.1	18.1
Louisiana†	134.8	66.7	34.8	10.5	37.5	30.4
Indiana	110.3	139.8	96.9	4.4	6.0	8.4
Utah	113.1	77.2	47.6	37.7	28.1	31.5
Montana	138.1	167.2	48.3	8.9	20.9	23.6
Kansas	128.1	127.9	73.7	17.3	34.9	28.0
Idaho	163.2	161.4	40.3	34.2	40.3	23.8
North Dakota	128.1	143.2	52.3	10.9	29.6	32.0
South Dakota	142.2	178.3	56.2	24.8	62.0	50.0
Virginia†	100.7	89.8	58.4	20.8	29.9	49.5
Florida†	105.5	103.3	47.4	17.1	42.3	52.5
Arizona	120.7	108.2	26.4	14.8	59.2	141.2
Nevada	133.7	87.0	60.5	58.8	37.3	67.6
Wyoming	88.0	107.7	52.0	11.7	33.1	37.9
Kentucky†	124.4	‡	59.3	15.9	‡	34.3
West Virginia	100.7	97.8	43.7	17.9	41.8	29.9
Alabama†	83.4	91.4	46.0	30.6	48.7	55.7
Mississippi†	106.5	‡	49.6	61.2	‡	71.5
Georgia†	102.3	‡	48.4	18.2	‡	59.5
North Carolina†	72.6	63.7	44.3	20.5	40.8	78.3
Tennessee†	98.7	‡	50.0	58.5	‡	93.5
Oklahoma†	86.4	95.7	31.9	39.8	98.6	38.5
South Carolina†	98.4	50.3	34.5	15.7	18.3	43.5
New Mexico	83.3	90.9	33.7	178.9	180.1	419.2
Arkansas†	109.1	74.5	34.4	30.3	47.8	68.6

*Excludes Georgia, Kentucky, Maine, Mississippi, Tennessee, and Vermont.
†White population only.
‡Combined with rural death rate.

Arkansas—the mortality ascribed to senility and ill-defined causes actually exceeded the reported cancer death rate. This situation at least suggests that the character and adequacy of the medical service have much to do with the size of the cancer rate.

In view of this situation one would expect to find the differences even more pronounced between cities and the rural regions. Table II, shows that generally the highest cancer death rates and the lowest "ill-defined" death rates are found in the large cities; the reverse in the rural areas. Furthermore, the more rural the area, the fewer are the deaths attributed to cancer and the more numerous are those assigned to senility and the ill-defined causes. The total crude cancer death rates for urban and rural divisions of 41 States during the single year 1930 were as follows: in cities, 120.8; small incorporated places, 115.0; and strictly rural areas, 71.2. The corresponding rates per 100,000 from senility and the ill-defined causes were: in cities, 8.5; in small incorporated places, 26.4; and in strictly rural areas, 43.4. It is especially significant that in 12 States the rural areas actually reported more deaths from "ill-defined" causes than from cancer. All of these States, by the way, were situated in the southern half of the country. Only three Southern States, namely, Kentucky, Virginia, and Louisiana, deviated from this rule, and in each of these the rural "ill-defined" rate closely approximated that ascribed to cancer.

It must not be assumed, however, that the wide differences in the cancer mortality rate of the various States can be attributed solely to the differences in their respective death rates from the "ill-defined" causes. Doubtless many "ill-defined" deaths, if properly allocated, would be assigned to causes other than cancer. A high "ill-defined" death rate indicates faulty diagnosis or a high percentage of cases in which there was little or no medical attendance. The fact that in so many cases the cause of death was undetermined suggests that in many other cases the true cause was erroneously recorded. Under such conditions the existence of cancer is less likely to be discovered. Consequently not only are many deaths due to this cause classified as "ill-defined", but it is also highly probable that many more such deaths are improperly assigned to other causes.

Until first-class medical service is available to all sections of the population, and until registration is more uniform, complete, and accurate in all parts of the country, comparison of death rates from certain causes of death between one State or section and another, or between urban and rural areas will be rather hazardous. This applies, especially, to cancer and to other chronic diseases with a high incidence among elderly persons; for it is within this element of the population that inaccuracies in death certification are most frequent.

Health Record for May 1935

PROSPECTS for a year favorable in every important aspect of the public health have never been brighter than in 1935. This is indicated by the low level of mortality that has prevailed for the first five months of the year among approximately seventeen million Industrial policyholders of the Metropolitan Life Insurance Company.

In this important cross-section of the population the year-to-date rate for January to May, inclusive, was 2.5 percent below the figure for the same months of 1934, which year, in turn, registered the lowest mortality rate on record.

Furthermore, the 1935 record for the principal individual causes of death is as remarkable as that for all causes combined. Every one of the seven major causes, which, together, are responsible for two out of every three deaths that occur, is recording a drop from last year's figure. The declines range from 8 percent for chronic nephritis to $^{7}/_{10}$ of 1 percent for cancer. Particularly favorable items in the 1935 health picture are decreases of 5.2 percent for tuberculosis and 4.7 percent for heart disease, and the drop in the cancer mortality rate, which although small, is in marked contrast with the long series of increases previously observed in the crude death rate for this disease.

Likewise, the 1935 record is excellent for certain diseases which are less important from the standpoint of numbers, but are nevertheless of major public health interest. For example, deaths from the four principal communicable diseases of childhood have dropped by more than 10 percent in a single year; and the mortality from puerperal conditions has declined, despite the fact that an increase in the birth rate, observed in 1934, has probably extended into 1935. Furthermore, slight drops are in evidence in the mortality from suicides, homicides, and automobile fatalities.

The only two important diseases to show higher mortality than during the January–May period of 1934 are influenza and coronary conditions; and the death rate for the former is still below the average, despite the rise.

The death rate in the general population of the large cities of the United States during the month of May was 11.9 per 1,000 estimated population, as compared with 12.2 for the preceding month of April and with 11.7 for May 1934. The diseases which showed increased prevalence as compared with April were poliomyelitis, smallpox, and typhoid fever; those for which fewer cases were recorded were diphtheria, influenza, measles, and scarlet fever. Comparison with May 1934 shows more cases of scarlet fever and smallpox together with lower prevalence of diphtheria, influenza, measles, poliomyelitis, and typhoid fever.

There was the usual seasonal increase in poliomyelitis, with 46

States reporting 107 cases in May as compared with 74 in April. The largest increase occurred in North Carolina, namely, from seven to 22 cases.

The following items are of special public health interest: The Chicago Department of Health, in a study of death certificates of infants who were born and who died in some of the larger hospitals, found that the death rate of premature infants under 15 days of age varied from a low of five per 1,000 births in some institutions to 50 per 1,000 in others. The low rates in some hospitals were attributed to the maintenance of high standards of incubator care and resuscitation and to the earnest efforts to obtain breast milk for babies until mothers' milk became available.

A new health district has been established in Tompkins County, N. Y., as a cooperative project of the United States Public Health Service, the New York State Department of Health and the TOMPKINS COUNTY DEVELOPMENT ASSOCIATION. This new district is the first to be developed under the plan for Federal aid to rural areas for health work.

A new cancer commission has been appointed in the Province of Ontario to continue a cancer program which was begun several years ago. Three clinics have already been established, namely, in Toronto, Kingston, and London. The NATIONAL TUBERCULOSIS ASSOCIATION has announced that its study on the standardization of x-ray technique, which has been conducted for the past 10 years, has now reached a point where effective advisory service can be given to the x-ray departments of hospitals and sanatoriums.

A preliminary report on the medical services and facilities of Utah has been completed by the Committee on Economics of the UTAH STATE MEDICAL ASSOCIATION. This State has to contend with unusual difficulties with respect to the provision of adequate medical care on account of the low density of its population. Various recommendations are made for the improvement of medical services in Utah. Many recommendations for improving maternity care and reducing maternal mortality in New York City have been made in reports submitted to the Commissioner of Health by the Advisory Obstetrical Council. One recommendation provides for the closing of the BELLEVUE TRAINING SCHOOL FOR MIDWIVES. New educational material for expectant mothers is also recommended.

The following table shows the mortality among Industrial policyholders for May 1935; April 1935, and May 1934, together with the cumulative rates for the first five months of each year.

METROPOLITAN LIFE INSURANCE COMPANY

Death Rates per 100,000 for Principal Causes. Weekly Premium-Paying Business in Industrial Department. All Ages (Annual Basis).*

MONTHS OF MAY 1935; APRIL 1935, AND MAY 1934.

CAUSES OF DEATH	ANNUAL RATE PER 100,000 LIVES EXPOSED*				
	May 1935	April 1935	May 1934	Cumulative January-May	
				1935	1934
TOTAL—ALL CAUSES	880.9	901.8	883.2	921.5	944.8
Typhoid fever	0.6	1.0	0.7	0.5	1.0
Measles	5.8	5.2	6.1	3.8	4.8
Scarlet fever	4.3	4.2	2.0	3.8	3.5
Whooping cough	3.6	3.0	4.3	3.3	4.0
Diphtheria	1.3	1.9	1.3	2.1	2.2
Influenza	12.5	17.4	11.2	25.4	17.8
Tuberculosis (all forms)	58.7	62.2	64.4	59.7	63.0
Tuberculosis of respiratory system	51.9	55.8	57.0	53.9	55.6
Syphilis, locomotor ataxia and general paralysis of the insane	11.0	10.3	13.4	11.3	12.8
Cancer (all forms)	90.5	94.0	94.0	94.7	95.4
Diabetes mellitus	23.4	26.8	23.2	26.9	27.0
Cerebral hemorrhage; apoplexy	63.3	66.5	66.0	66.5	70.6
Diseases of heart†	164.4	169.9	167.5	176.5	185.3
Diseases of the coronary arteries and angina pectoris	30.7	33.3	30.9	34.4	31.9
Pneumonia (all forms)	86.9	90.3	78.3	96.8	97.8
Diarrhea and enteritis	6.8	6.5	8.8	6.1	7.1
Appendicitis	11.8	12.0	13.3	11.5	12.5
Chronic nephritis (Bright's disease)	62.3	63.3	62.6	65.3	71.0
Puerperal state—Total	7.8	8.5	9.1	9.3	9.7
Suicides	10.1	8.6	11.1	8.8	9.8
Homicides	5.0	4.9	6.0	5.5	5.6
Accidents—Total	50.9	48.2	49.6	51.6	52.2
Automobile accidents	19.7	16.1	16.8	18.4	18.7
All other diseases and conditions	169.2	163.7	159.4	157.6	159.7

*The rates for 1935 are subject to slight correction, since they are based on provisional estimates of lives exposed to risk.

†Excludes pericarditis, acute endocarditis, and acute myocarditis.

Correspondence on the subjects discussed in these BULLETINS may be addressed to: The Editor,

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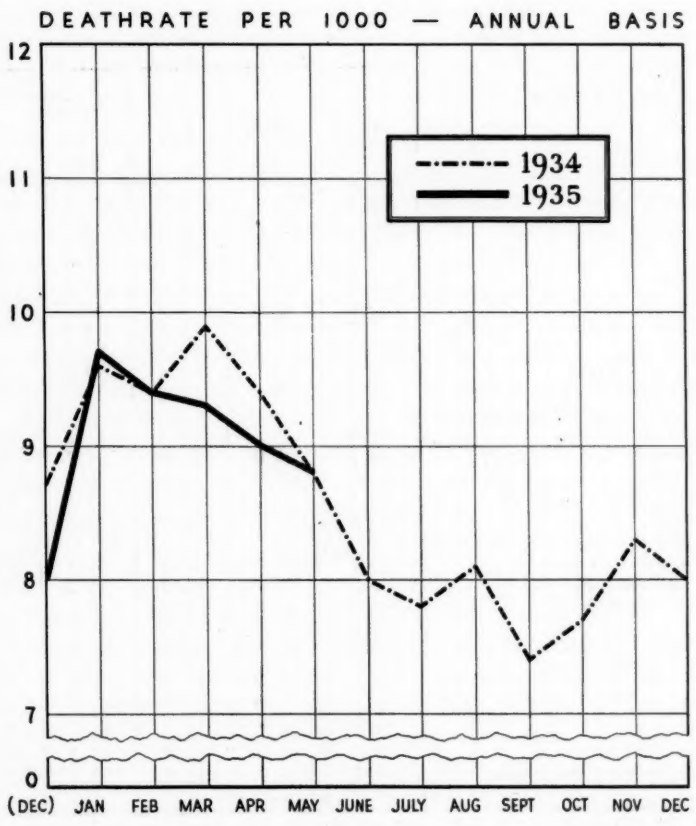
DEATHRATES FROM ALL CAUSES

METROPOLITAN LIFE INSURANCE CO. – INDUSTRIAL DEP'T.
WEEKLY PREMIUM PAYING BUSINESS — TOTAL PERSONS



1934	9.6	9.4	9.9	9.4	8.8	8.0	7.8	8.1	7.4	7.7	8.3	8.0
1935*	9.7	9.4	9.3	9.0	8.8							

** Rates for 1935 are provisional*

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